Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INTEGRA SPECIALTY GROUP PA
P O BOX 535966
GRAND PRAIRIE TX 75053

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-12-0591-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Take From the Table of Disputed Services: "No EOB/Pre-authorized - #00011EGA2127…No EOB Received."

Amount in Dispute: $3,839.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider submitted the disputed billing to the Carrier outside the timeframe required by Rule 133.20(b). Per Rule 102.4(h), the submission date is the later of the signature date or the date received minus five days. In this instance, the received date is the later date, as shown by the bill image attached. Based on Rule 102.4(h), the Carrier received the billing in dispute on 09-21-2011, which makes the submission date 09-16-2011. This date is 307 days after the final date of service 11-18-2011 and 225 days after the final date of service 02-08-2011. Therefore the Provider's billing was not timely submitted within 95 days as required by Rule 133.20(b), and the Provider is not entitled to reimbursement."

Response Submitted by: Travelers, 1501 S. Mopac Expressway, Suite A-320, Austin, Texas 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2010 To February 8, 2011	97032, 97035, 97110, 97112, 97140, 99080-73, 99213, 95851, 95833, 97545-WH, 97456-WH	$3,839.48	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits dated October 1, 2011
   - TXH3-29 – THE TIME LIMIT FOR FILING HAS EXPIRED. PER TEXAS LABOR CODE 480.027, BILLS MUST BE SENT TO THE CARRIER ON A TIMELY BASIS, WITHIN 95 DAYS FROM DATES OF SERVCIE.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Did the requestor forfeit their right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to sufficiently support that any of the exceptions described in Texas Labor Code§408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
2. Review of the requestor's submitted information finds a copy of a certified mail return receipt and itemized listing of Article Number 7010 2780 0000 9111 9611 with a sent date of September 19, 2011, and a return receipt signed by Willie G. A Johnson, a representative of Travelers Indemnity, on September 21, 2011 in support of its position that the medical bills were timely filed with the insurance carrier. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §103.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the requestor's submitted information finds no documentation to sufficiently support that a medical bill was submitted within 95 days from the date the services were provided. Therefore, pursuant to Texas Labor Code §408.027(a), the requestor in this medical fee dispute has forfeited their right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 9, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.